IDAHO COUNCIL ON CHILDREN'S MENTAL HEALTH

Recommendation #26A: By July 1, 2001, the ICCMH will appoint a task force, which includes the groups identified in the recommendation and family representatives to develop and oversee implementation of minimum standards for a local crisis response protocol. The task force will consider the most effective method of initial crisis assessment. At a minimum, there will be a local or statewide (800) telephone number with an individual who is qualified to assess the situation and connect callers to the appropriate crisis response personnel. The task force will also assess the current status of children's mental health crisis response to determine what is currently in place as a baseline for developing the protocol.

SUBMITTED TO ICCMH: **January 15, 2002**
APPROVAL DATE: **January 15, 2002**
DECISION: The ICCMH approved the following Crisis Response Protocol as submitted.

ESTABLISHING COMMUNITY CHILDREN'S MENTAL HEALTH EMERGENCY SERVICE PROTOCOLS

Idaho Council on Children's Mental Health
Task Force on Crisis Response

December 11, 2001

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ESTABLISHING COMMUNITY MENTAL HEALTH EMERGENCY SERVICE PROTOCOLS - IDAHO

BACKGROUND INFORMATION

PREFACE:

Provision of emergency/crisis services goes to the very heart of what is perhaps the major role and responsibility of government and public services, e.g. public safety. Idaho statute, the Children's Mental Health Services Act, as well as the Child Protective Act, clearly identifies/mandates a role for the Department of Health and Welfare (DHW) in mental health emergency situations. Additionally, statute also describes roles for law enforcement, county governments and education in both service planning and developing comprehensive services ensuring the best use of public and private resources provision.

> Idaho statute 16-2403 defines mental health emergency as follows: *" means a situation in which the child's condition, as evidenced by recent behavior, poses a significant threat to the health or safety of the child, his family or others, or poses a serious risk of substantial deterioration in the child's condition which cannot be eliminated by the use of supportive services or intervention by the child's parents, or mental health professionals, and treatment in the community while the child remains in his family home".*

Emergency and crisis response services are one of the primary responsibilities of the Department of Health and Welfare and other public agencies. Any community's mental health service system is only as good as its emergency system.

COMMUNITY PROTOCOLS:

A community's emergency service system best involves a multi-agency response, as no single agency is broad enough in scope, resources or authority to effectively resolve the emergency situation. The multi-agency response is best accomplished by communities developing a multi-agency protocol outlining the response process as well as identifying various agency roles and responsibilities in mental health emergency service provision.

ISSUES/CHALLENGES FACING COMMUNITY-BASED EMERGENCY SYSTEMS:

As communities seek to find solutions to difficult situations arising from mental health crisis, they face a number of challenges. By addressing the following

challenges, communities will be able to realize progress in their efforts to develop emergency response protocols:

- System turf issues and institutionalized efforts (reinforcement) of "cost shifting" and client ownership/responsibility
- Lack of coordination among different service systems
- Complex challenges of financing crisis services
- Staffing difficulties including recruiting staff, obtaining qualified staff, and staff burnout (retention)
- A need for more adequate case management
- A lack of available services and resources for follow-up care
- A lack of crisis services, as well as other services, for the increasing number of youth who are severely troubled resulting in an overtaxing of existing services
- Existing local/state regulatory standards and potential legal risk(s)

GUIDELINES FOR DEVELOPING A COMMUNITY-BASED EMERGENCY SYSTEM:

Effective community-based crisis response protocols must address, at a minimum, eight basic areas:

1) Mission and core values;
2) Program goals;
3) Ethical standards and confidentiality;
4) Target population for emergency services;
5) Points of access to emergency services;
6) Emergency/crisis intervention model;
7) Emergency services continuum/array; and
8) Administrative procedures.

MISSION AND CORE VALUES:

Participating community agencies need to have a common, agreed upon set of values and vision around which the system is built. The values form the foundation for what needs to come later. Without agreement on this key area, participating agencies will not be able to agree on the specifics and details of the protocols.

Following are the mission and core values recommended by the ICCMH's Task Force on Crisis Response:

MISSION:

"To promote the health and safety of children experiencing a mental health emergency, by providing a coordinated emergency response system."

CORE VALUES:

1. Child-Centered and Family-Focused: The unique needs of the child and the family determine the types and mix of services provided.

2. Community Based: The locus of services as well as management and decision-making responsibility begins in the community.

3. Culturally Competent: Agencies, programs and services are responsive to the cultural, racial and ethnic differences of the populations they serve.

4. Least Restrictive Environment: Available services, including transportation and evaluation, should be provided in the least restrictive environment that is consistent with safe and effective crisis intervention. Restraint and seclusion shall be used only when absolutely necessary.

5. Family Involvement: The child's family should be involved in all aspects of planning and delivery of services.

6. Collaboration: Emergency services should be coordinated and integrated among child serving agencies.

PROGRAM GOALS OF THE LOCAL EMERGENCY SYSTEM:

System goals provide a framework around which the program can ultimately be evaluated. Recommended program goals are as follows:

- Provide a timely response to prevent injury or harm to the child or others
- Provide cost-effective services in response to children's mental health crises
- Reduce children's mental health crises by linking children and families to available resources
- Prevent repeated hospitalizations whenever there is a crisis
- Prevent out-of-home placements

ETHICAL STANDARDS AND CONFIDENTIALITY:

All agencies and individuals involved shall follow standards regarding conduct and ethics pertaining to their professional affiliation.

Objectives:

1) to protect the rights of persons receiving crisis intervention services
2) to promote compliance with professional and community standards of conduct

CRISIS SERVICES TARGET POPULATION:

Children under the age of eighteen (18) whose mental or emotional state in the absence of immediate response:

- poses a significant threat to the health or safety of the child;
- poses a significant threat to the health or safety of others; or
- poses a significant risk of substantial deterioration in the child's condition

POINT OF ACCESS TO EMERGENCY SERVICES:

A protocol must address how emergency services are accessed, both the access point as well as the pathway.

The ICCMH's Task Force on Crisis Response recommends that each Region establish a toll free telephone number accessible twenty-four (24) hours per day, seven (7) days per week.

Screening and triage for the emergency response systems are provided through this single point of access. Each protocol will address how cases are triaged.

Referrals to the emergency response system come from a variety of different sources. The following are guidelines for accepting referrals to the emergency response system:

Self Referrals:

Idaho statute vests parents or legal guardians with the authority to provide consent for treatment of a minor child. If a minor child is self-referring directly to the regional crisis response system, the emergency system staff will make every effort to locate the parents and obtain consent and instruction. If parents are unable to be located, or are otherwise unwilling or unavailable to provide voluntary consent and an evaluation indicates the likelihood of physical harm or an inability to maintain health and safety of the youth, the crisis staff shall initiate proceedings for emergency detention, transportation, admission, evaluation and treatment. This may be accomplished through the police protective custody process (16-2411) or by the completion of a Designated Examination with arrangements for

ambulance or police transport (16-2412). It shall be specified in the local protocol how this provision is to be implemented.

Parent Referrals:

The parent may contact the emergency system, which will provide consultation and assist in making arrangements for transportation and an assessment at an appropriate and safe location. This may include the parents providing transportation or it may involve utilizing law enforcement whichever is most appropriate considering clinical and safety needs. Specific processes for accessing the emergency system will be outlined further in the body of the protocols.

Third Party Referrals:

When a third party makes referrals to the emergency system, the referral source will be asked to contact the parents informing them of the situation and circumstances of the emergency. In each situation the emergency system staff shall contact the parents.

EMERGENCY CRISIS INTERVENTION MODEL:

A useful crisis response model identifies three functions or steps with associated tasks to be accomplished in any crisis situation. The model is a risk reduction/risk management model, which separates the crisis response function into three stages. Below find the model chosen by the ICCMH's Task Force on Crisis Response.

1. STAGE ONE: Assessment/Evaluation of the risk

- Risk assessment to safety (self, others, community)

2. STAGE TWO: Acute Emergency Intervention

- Risk management, decrease risk
- Stabilize situation; make it "safe" until follow-up care can be arranged and provided

3. STAGE THREE: Follow-up arrangements

- Arrange for referral, provision for treatment of underlying issue(s) condition

EMERGENCY SERVICES ARRAY AND CONTINUUM:

An emergency service system is best thought of as a continuum of services and responses. An emergency service response continuum is shown below:

Crisis Telephone Services

Walk-In Face-To-Face Intervention (facility based)

Mobile Crisis Outreach Services

Flexible Individualized Services

Crisis Residential

Hospitalization (acute short-term inpatient)

ADMINISTRATIVE PROCEDURES:

DHW will be the lead agency for completing children's mental health emergency response protocols.

For quality assurance, mandatory participants shall review each protocol annually to insure needs are being addressed in an efficient, cost effective manner. The results of this review will be documented and provided to the regional councils.

Procedures will be developed to address training requirements for emergency crisis response staff. (See Appendix D)

Each regional council will create a Children's Mental Health Emergency Response Dissemination Plan, identifying responding agency(ies), the toll free number, what a children's mental health emergency is and what the caller can expect. (See Appendix E)

Emergency response protocols will be provided to regional/local councils. Implementation and adherence to protocols as well as review of outcomes will be monitored by the ICCMH as part of their overall monitoring plan via the regional councils. Data will be collected and the ICCMH will provide direction

SUMMARY:

Community leaders must recognize and address the complicated interplay of factors across agencies and negotiation of agency boundaries needed in order to have effective emergency response systems. In order to achieve desired outcomes and meet established program goals, system processes and resources must be coordinated. It is beyond the scope of one single agency to accomplish an integrated community-based emergency system. Establishing protocols that identify resources, processes, and roles for the various community agencies is a first step.

APPENDIX A:

MINIMUM STANDARDS FOR EMERGENCY RESPONSE PROTOCOLS

MINIMUM STANDARDS FOR SCREENING/TRIAGE AND ASSESSMENT:

1) Screening will be available 24 hours a day seven days a week.
2) Each protocol will identify a toll free telephone number for emergency crisis response.
3) Staff responding to emergency situations shall:
    - have a minimum of a Bachelor's Degree in social work, psychology, or closely related human services field.
    - have 24-hour access to a clinical supervisor or a qualified mental health professional.
4) Complete screening/triage and assessment form
5) Face to face evaluations will be conducted in a timely manner where available and clinically appropriate.
6) A written safety plan will be developed to address emergent needs, through risk reduction and crisis stabilization.
7) Safety plan will include, if necessary, the plan for transporting children/youth to emergency facility.
8) Screening will be conducted with informed consent of parents/guardians whenever possible. (See referral source section for standard around parental consent).

MINIMUM STANDARDS FOR EMERGENCY INTERVENTION:

1) Staff responding to emergency situations shall:
    - have a minimum of a Bachelor's Degree in social work, psychology, or closely related human services field.
    - have 24-hour access to a clinical supervisor or a qualified mental health professional.
    - respond by telephone within 10 minutes to incoming emergency calls 24 hours a day, 7 days per week
2) Intervention will be conducted face to face where possible and clinically appropriate.
3) A written safety plan will be completed on every child that outlines the necessary steps to ensure safety of the child and others.
4) Each protocol will identify how the mental health emergency response system will coordinate and interact with local law enforcement.
5) Each protocol will address the coordination and collaboration between the emergency mental health system and facilities/institutions:

- Juvenile detention
- Juvenile correction facilities
- Residential treatment facilities
- Hospitals
- Schools

MINIMUM STANDARDS FOR FOLLOW-UP:

1) The family will be contacted within five calendar days regarding the status of the crisis situation and encouraged to access ongoing preventative services.

2) For every child referred to the emergency crisis response system, a letter outlining services available through DHW and other child serving agencies will be sent to parents/guardians.

3) Contacts will be documented and available for review upon written request and accompanied by appropriate release of confidential information signed by parent/guardian is in place.

APPENDIX B:

PROTOCOL TEMPLATE

This is a template for the children's mental health crisis protocols that will be developed. **Bold** print shall be included in each protocol to maintain statewide consistency. Each protocol will address the subject areas below recognizing available community resources. (See Appendix A for protocol minimum standards established by the ICCMH Task Force on Crisis Response.) Technical assistance from the ICCMH is available to assist communities in the development of the protocols.

MISSION AND CORE VALUES:

MISSION:

"To promote the health and safety of children experiencing a mental health emergency, by providing a coordinated emergency response system."

CORE VALUES:

1. **Child-Centered and Family-Focused: The unique needs of the child and the family determine the types and mix of services provided.**

2. **Community Based: The locus of services as well as management and decision-making responsibility begins in the community.**

3. **Culturally Competent: Agencies, programs and services are responsive to the cultural, racial and ethnic differences of the populations they serve.**

4. **Least Restrictive Environment: Available services, including transportation and evaluation, should be provided in the least restrictive environment that is consistent with safe and effective crisis intervention. Restraint and seclusion shall be used only when absolutely necessary.**

5. **Family Involvement: The child's family should be involved in all aspects of planning and delivery of services.**

6. **Collaboration: Emergency services should be coordinated and integrated among child serving agencies.**

PROGRAM GOALS OF THE LOCAL EMERGENCY SYSTEM:

- **Provide a timely response to prevent injury or harm to the child or others**
- **Provide cost-effective services in response to children's mental health crises**
- **Reduce children's mental health crises by linking children and families to available resources**
- **Prevent repeated hospitalizations whenever there is a crisis**
- **Prevent out-of-home placements**

ETHICAL STANDARDS AND CONFIDENTIALITY:

- **Crisis response staff shall adhere to all state, federal laws, and professional ethical standards.**
- **A primary responsibility of the crisis response staff is to maintain the confidentiality of information about persons being helped.**
- **Confidential information may be revealed if there is indication of clear and present danger to self and others.**
- **Except for situations that indicate clear and present danger to self and others, information may only be disclosed with written release of information by parent/guardian and by the child when required by law. The release must specify what information may be given and to whom.**
- **The crisis response staff shall assure that appropriate provisions are made for the maintenance of confidentiality in the storage, retrieval, use and ultimate disposition of records.**

TARGET POPULATION FOR EMERGENCY SERVICES:

Children under the age of eighteen (18) whose mental or emotional state in the absence of immediate response:

- **poses a significant threat to the health or safety of the child;**
- **poses a significant threat to the health or safety of others; or**
- **poses a significant risk of substantial deterioration in the child's condition**

POINT OF ACCESS TO EMERGENCY SERVICES:

The toll free telephone number accessible twenty-four (24) hours per day, seven (7) days per week is _____.

Access to the emergency crisis response system is as follows:

Self Referrals:

Idaho statute vests parents or legal guardians with the authority to provide consent for treatment of a minor child. If a minor child is self-referring directly to the regional crisis response system, the emergency system staff will make every effort to locate the parents and obtain consent and instruction. If parents are unable to be located, or are otherwise unwilling or unavailable to provide voluntary consent and an evaluation indicates the likelihood of physical harm or an inability to maintain health and safety of the youth, the crisis staff shall initiate proceedings for emergency detention, transportation, admission, evaluation and treatment. This may be accomplished through the police protective custody process (16-2411) or by the completion of a Designated Examination with arrangements for ambulance or police transport (16-2412).

It shall be specified in the local protocol how this provision is to be implemented.

Parent Referrals:

The parent may contact the emergency system, which will provide consultation and assist in making arrangements for transportation and an assessment at an appropriate and safe location. This may include the parents providing transportation or it may involve utilizing law enforcement whichever is most appropriate considering clinical and safety needs.

Third Party Referrals:

When a third party makes referrals to the emergency system, the referral source will be asked to contact the parents informing them of the situation and circumstances of the emergency. In each situation the emergency system staff shall contact the parents.

EMERGENCY/CRISIS INTERVENTION MODEL:

Each protocol will identify the three functions or steps and associated tasks to be accomplished in any crisis situation. The three stages, as outlined in the background information document, are:

- Assessment/Evaluation
- Acute Emergency Intervention
- Follow-up

Each protocol will identify the associated tasks to be accomplished for the above three stages, including the minimum standards identified in Appendix A.

EMERGENCY SERVICES CONTINUUM/ARRAY:

Each protocol will develop a continuum/array of emergency services based on available resources in the community.

ADMINISTRATIVE PROCEDURES:

Each protocol will address review procedures, training requirements, and the relationship with the ICCMH and the regional/local councils.

Each protocol will address the coordination and collaboration between the emergency mental health system and facilities/institutions:

- Juvenile detention
- Juvenile correction facilities
- Residential treatment facilities
- Hospitals
- Schools

Participants have been identified in two groups, one that is a mandatory group for development and required signatures and one that is recommended. Mandatory participants in the emergency response protocols are:

- Department of Health and Welfare
- Law Enforcement
- Prosecuting Attorney
- In-patient facilities
- Any contracted agencies for emergency mental health services

Recommended participants are:

- School districts
- Department of Juvenile Corrections
- County Juvenile Probation/Detention
- Family Advocate Representative
- Private providers of emergency mental health services

APPENDIX C:

PLANNING FOR AND ASSESSING AN EMERGENCY RESPONSE SYSTEM:

When developing protocols for community-based emergency response and emergency service systems in general various models may be useful to1) guide community planning efforts and 2) to assist communities in self-assessment/evaluating the adequacy of their emergency response system (Report Card). The proposed model organizes an emergency community-response system along on four dimensions.

INTENSITY of SERVICES

1	2	3	4	5
←				→
1 hr. (or less) per episode upon referral				As intensive as needed

ACCESSIBILITY - LOCATION

1	2	3	4	5
←				→
One location, office-based or telephone contact only	Service seldom delivered outside office setting	Occasional non-office based emergency services	Frequent non-office based contacts (e.g. home, ER, school, detention)	Routine out-of-office emergency services

ACCESSIBILITY - TIME

1	2	3	4	5
←				→
Regular working Hrs (8-5, M-F)	Services seldom delivered outside regular office hrs	Occasional evening/ weekend services	Frequent flextime & evening services	24 hrs including weekends

ACCESSIBILITY – SERVICE TYPE

1	2	3	4	5
←				→
24 hr crisis telephone service	Emergency after hours face-to-face service capability	Various emergency services	Large array of emergency response/service capability	Full array of crisis services

SUB-SCORES:

Dimension I (Service Intensity) = _____
Dimension II (Accessibility – Location) = _____
Dimension III (Accessibility – Time) = _____ **GLOBAL SCORE:**

Dimension IV (Accessibility – Service Type) = _____ (average score)
TOTAL SCORE: = _____ _____

ASSESSEMENT OF IDAHO'S CURRENT COMMUNITY RESPONSE SYSTEMS:

The above evaluation model may serve as a tool which communities can use to assist in evaluating current status, adequacy and capacity for delivering emergency mental health services to children, youth and their families. Each community must ultimately decide for itself the level of development for its emergency response system. It is a matter of resource commitment and prioritization. A recommended minimum level of response development is a total score of 14 or global score of 3.5.

APPENDIX D:

CHILDREN'S MENTAL HEALTH EMERGENCY RESPONSE TRAINING CURRICULUM

Training will be available for all mandatory and recommended protocol participants. The Department of Health and Welfare will take the lead in developing and providing training related to children's mental health emergency response.

All participants will receive initial training in each of the five core competency areas. Training modules II, III and V will be reviewed annually with all participants.

I. CORE COMPETENCIES

Providers of emergency mental health services should have competencies in five knowledge/skill areas as follows:

1. Mental Status Exam and Basic Mental Health Assessment
2. Risk Assessment (Danger To Self/Suicide, Danger to Others)
3. Mental Health Law and Ethical Issues Related to Emergency Mental Health Services
4. Basics of Crisis Intervention
5. Resources, Service Options and Local Community Protocols and Processes

These 5 areas comprise the core competencies of mental health crisis/emergency service provision. The following training curriculum consists of five modules, one for each of the 5 competencies.

II. TRAINING MODULES

Each training module's lesson plan is organized as follows:

A. Statement of the core competency

B. Participant Learning Objectives

C. Materials/Methods Required

D. Time

T R A I N I N G M O D U L E I.

A. CORE COMPETENCY

MENTAL STATUS EXAM AND BASIC MENTAL HEALTH ASSESSMENT – THE CLINICAL INTERVIEW

B. LEARNING OBJECTIVES

1. Participants will be able to identify the major areas to be addressed in a mental status exam and demonstrate how to evaluate each (e.g. appearance and behavior; insight and judgement; mood/affect; sensorium and orientation; thought processes and perception; and intellectual functioning and cognition)
2. Participants will, based upon the results of the clinical interview, be able to formulate diagnosis' consistent with the DSM-IV multi-axial
3. Participants will learn the role of the clinical interview in risk assessment, the designated examination, the comprehensive assessment and the DSM-IV diagnostic system

Note: This module has the following pre-requisites:

- Basic understanding of DSM-IV
- Basic knowledge of and ability to perform comprehensive assessment

C. TRAINING METHODS/MATERIALS UTILIZED

- Lecture
- Slides
- Supporting handouts
- Role play and vignettes

D. TRAINING TIME REQUIRED

- 4 hours

T R A I N I N G M O D U L E II.

A. CORE COMPETENCY

MENTAL HEALTH RISK ASSESSEMENT – SUICIDE AND
RISK TO OTHERS

B. PARTICIPANT LEARNING OBJECTIVES

1. Participants will learn differential assessment for depression
2. Participants will learn model for assessment based on suicide risk domains
3. Participants will learn how to assess for a suicide PLAN
4. Participants will learn assessment domains and risk factors for determining potential risk to others (homicide/assault)

C. TRAINING METHODS/MATERIALS UTILIZIED

- Lecture
- Slides
- Supporting handouts
- Small group discussion and exercises

D. TRAINING TIME REQUIRED

- 4 hours

T R A I N I N G M O D U L E I I I.

A. CORE COMPETENCY

MENTAL HEALTH LAW AND ETHICAL CONSIDERATIONS RELATED TO CHILDRENS' MENTAL HEALTH CRISIS RESPONSE – CHILDREN & YOUTH

B. PARTICIPANTS LEARNING OBJECTIVES

1. Participants will become knowledgeable in the Children's Mental Health Services Act, especially those sections pertaining to emergency situations (e.g. consent for treatment, emergency evaluations and detainment, emergency treatment and patient rights).
2. Participants will become familiar with responsible ethical practice as it relates to children's mental health crisis response.

C. TRAINING METHODS/MATERIALS UTILIZED

- Lecture
- Slides
- Supporting handouts

D. TRAINING TIME REQUIRD

- 2.5 hours

T R A I N I N G M O D U L E IV.

A. CORE COMPETENCY

CRISIS INTERVENTION - THE BASICS

B. PARTICIPANTS LEARNING OBJECTIVES

1. Participants will learn crisis process(es)
2. Participants will learn three step model for crisis intervention
3. Participants will learn goals for crisis intervention services
4. Participants will learn service system options for crisis services
5. Participants will learn strategies/techniques for intervening in mental health emergency situations
6. Participants will learn importance of and how to engage families and to expand the "helping system" in emergency situations

C. TRAINING METHODS/MATERIALS UTILIZED

- Lecture
- Slides
- Handouts and supporting materials
- Vignettes and examples
- Small group discussion

D. TRAINING TIME REQUIRED

- 2.5 hours

T R A I N I N G M O D U L E V.

A. CORE COMPETENCY

LOCAL RESOURCES, RESPONSE OPTIONS, LOCAL COMMUNITY PROTOCOLS AND PROCESSES

B. PARTICIPANT LEARNING OBJECTIVES

1. Participants will learn local resources and emergency service system array
2. Participants will become familiar with local processes and protocols
3. Participants will be able to identify key agencies and their role(s) within the local emergency/crisis response system and access points

C. TRAINING METHODS AND MATERIALS UTILIZED

- Lecture
- Slide presentation
- Handouts and supporting materials, including local protocols
- Discussion by each identified agency representative

D. TRAINING TIME REQUIRED

- 1.5 hours

APPENDIX E:

CHILDREN'S MENTAL HEALTH EMERGENCY RESPONSE DISSEMINATION PLAN

THE PLAN WILL INCLUDE, AT A MINIMUM, HOW TO EDUCATE STAKEHOLDERS REGARDING:

WHAT A CHILDREN'S MENTAL HEALTH EMERGENCY IS:

A child under the age of eighteen (18) who:

- ***poses a significant threat to the health or safety of the child;***
- ***poses a significant threat to the health or safety of others; or***
- ***poses a significant risk of substantial deterioration in the child's condition***

WHO THE RESPONDING AGENCY IS

WHAT THE TOLL FREE TELEPHONE NUMBER IS

WHAT THE CALLER CAN EXPECT

Telephone response is available 24 hours a day, 7 days per week.

THE PLAN SHALL, AT A MINIMUM, BE DISTRIBUTED TO:

- Law Enforcement
- Prosecuting Attorney
- Schools
- Juvenile Justice Agencies
- Community Mental Health Providers
- Department of Health and Welfare, CMH, CPS
- Hospitals
- In-patient Facilities
- Children's Healthcare Providers
- Advocacy Groups

ADDITIONAL PLANS FOR DISTRIBUTION COULD INCLUDE:

- Public Service Announcements
- Print Media (i.e. telephone directories, newspapers)
- Refrigerator Magnets
- Health Fairs
- Childcare Providers